Covid-19 : A risk assessment too far? A blog by David Osborn

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Summary

In this blog I describe the biggest abuse of the health and safety system in living memory. It relates to the misuse and abuse of 'risk assessment', the very cornerstone of workplace health and safety. I explain how this left hundreds of thousands of healthcare

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workers (HCWs) at risk of catching Covid-19 as they provided close-quarter care to infectious patients. In turn, this paved the way for onward transmission to other patients, healthcare colleagues and their own families at home.

Risk assessment, when used correctly by responsible, properly trained and competent people is a powerful weapon in the armoury of tools available to protect workers against injury,

disease and death as they go about their work. However, as I will discuss, in the wrong hands, used by people lacking in basic health and safety competencies who may have misplaced objectives and motivations, it can be a very dangerous thing indeed.

Although some parts of this blog will be familiar to readers of my previous blogs, as the narrative unfolds you will see that I introduce new information evidenced by emails and other correspondenc

e obtained through Freedom of Information (FOI) requests.*

**Note: This blog contains no information that is subject to the UK Covid-19 Public Inquiry confidentiality undertakings.*

Content

Abuse of the system

During my 30 years in the health and safety profession I have come across so many instances where health and safety has been used as a means of doing all the wrong things for all

the wrong reasons when really it is a force for good. For instance, it has been used:

- As a convenient and lazy excuse to justify unpopular decisions or cover up management failures.
- To 'cover the corporate back' without real intere

st or regard for worke rs' safety.
- As an attem pt to justify insuffi cient risk contro l meas ures in order to avoid the additi onal time, troubl e and cost involv ed in providi ng the proper protec tions.

In this story, it seems that all of the above apply.

What is risk assessment ?

It is the fundamental principle underlying good health and safety management. Simply put, risk assessment involves **identifying a hazard** (anything that can cause harm), considering what the likelihood and consequences of it happening might be, and deciding what needs to be done in order to control risks and prevent the

harm occurring.

The reason I have emphasised 'identifying a hazard' is because it is important to this story—if you cannot identify a hazard then you cannot do a risk assessment.

So what went wrong in the pandemic?

There is no single answer to this. There were multiple factors that all came together in a 'perfect storm', resulting in an unmitigated disaster of disease spreading rife

through our hospitals, the ambulance service, care homes, etc.

How does Covid spread between people?

Covid-19 is an airborne disease. As an infected person breathes out, speaks, coughs or sneezes they emit thousands of tiny droplets known as aerosols into the air around them. These aerosols contain the virus and any person who then inhales this air is at risk of catching the disease. There may also be some element

of transmission due to a person touching contaminated surfaces and then touching their mouth, nose or eyes. On occasions, it is just conceivable that large 'ballistic' droplets (as they are called) may be expelled from a person's nose or mouth while coughing or sneezing and just happen to land on another person's mouth nose or eyes, thereby initiating the disease.

We all remember the early days of the pandemic with Government's

reassuring messaging that "*washing hands and singing happy birthday twice*" was a good way to protect ourselves against the disease. While not decrying the benefits of good hand hygiene, this was dangerous misinformation in the extreme, the fallacy of which still persists in people's minds to this day. Back then it perhaps served the Health Secretary's purpose in preventing panic and a 'loo roll' type rush on face masks and respirators which were needed by

doctors and nurses. One can only speculate how many lives could have been saved during the first wave had the public been told the truth about airborne transmission and how best to protect themselves. Happily, by the autumn of 2020, Government messaging had changed, emphasising the importance of opening windows to let the infectious aerosols escape.

However, while the virus was accepted as 'airborne' in people's homes,

bizarrely it was 'not airborne' in hospital wards, ambulances, etc, and staff were still denied the necessary protection against an airborne disease.

Who are the main 'actors' in this story?

The 'IPC Cell'

A group of individuals, mostly from the Infection Prevention and Control (IPC) profession, whose identities have been kept a closely guarded secret. It is unclear how the individual members of

the cell were selected or what selection criteria were used. A colleague's FOI request revealed that 28 were from NHS England, 3 from Wales, 3 from Northern Ireland, 4 from Scotland and 3 from Public Health England (PHE)/UK Health Security Agency. They were mostly IPC nurses and doctors, with one or two having specialisms, such as microbiology and epidemiology, or representing particular professions, such as the ambulance service and

dentistry. Curiously, the National Incident Director (Professor Sir Keith Willett) was identified as a member of the Cell, and played a pivotal role at the highest level and will have had oversight of the position regarding personal protective equipment (PPE) availability and shortages, but seemingly did not having a background or specialism in IPC.

Bizarrely, within the IPC Cell there were no specialists in the fields of occupational

hygiene or occupational health and safety; i.e. with training and competency in workplace risk assessment, management and control, or indeed competency in respiratory protective equipment (RPE). Neither were there any aerosol scientists or ventilation engineers in the Cell. It seems that the Health and Safety Executive (HSE), who would have been best positioned to specify PPE requirements for HCW protection, were either not

invited to join the Cell or, if they were, declined the invitation.

The one-time Chair of the IPC Cell, Dr Lisa Ritchie, at a meeting with colleagues of mine in August 2022, is on record confirming that "*at first, the IPC (Cell) had no experience of the hierarchy of controls, but it was a rapid learning curve*".

This is shocking. **The 'hierarchy of controls' is the most fundamental, basic principle of health and safety management.** It is something

that is covered in even the most simple, entry-level health and safety training courses. If you don't know about the hierarchy of controls then you are not a fit and proper person to undertake health and safety risk assessments, nor are you in a position to instruct others to do them when you don't understand the basic principles yourself.

The IPC Cell produced the 'National IPC Guidance,' which dictated the arrangements for health and

safety of HCWs across the UK during the pandemic. Unlike most of the other groups and committees (SAGE, NERVTAG, etc) the IPC Cell never published minutes of their meetings. Attempts to obtain these minutes through FOI requests have been met with refusals, delays and obfuscation. Even now, the Department of Health and Social Care is refusing FOI requests for minutes of their top level 'PPE Decision Making Committee' meetings and

have denied that such a committee ever existed.

The few sets of IPC Cell minutes which have trickled into the public domain from the midst of the second wave demonstrate that:

- these people had the power to reject PHE's recommendations that FFP3 respirators should be used

much more widely when providing care to infectious patients;
- they were concerned that if they were to change their advice, HCWs would realise they had been under protected in the past.

This would mean that they (the IPC Cell members) could be held legally accountable for their previous wrongful advice. Indeed, many consider that they should still be. So HCWs contin

ued to pay the price (some, the ultima te price) while Cell memb ers ‘cover ed their backs’ .

It is beyond belief that a group of people with such minimal understanding of occupational health and safety should be assigned the power and ‘life and death’ responsibility for the health and safety of over 1.2 million

people working in the NHS confronting a lethal virus, let alone all those working in social and domiciliary care. Their performance during Covid-19 can only be described as an abject failure (witness the thousands of patient deaths and catastrophic levels of disease and death amongst HCWs). Some of these people still occupy positions of responsibility for IPC and this really does not bode well for the next pandemic whenever it may strike. For the future

safety of the nation, the whole system (and the people within it) needs an overhaul.

IPC practitioners are members of an essential and well-respected profession. However, the conduct of some members of the IPC Cell, including the Chairs of the Cell from June 2020 onwards, Dr Ritchie and Dr Eleri Davies, have dealt the profession a hammer blow in respect of its reputation and credibility arising from their refusal to budge from their 'droplet dogma' and

rejection of expert advice from PHE.

On 16 Sep 2024, I watched with utter incredulity at Dr Ritchie giving her evidence at the UK Covid-19 Inquiry. When challenged with Professor Beggs' IPC expert evidence concerning airborne transmission of Covid-19, Dr Ritchie appeared to contradict him by stating that the epidemiology and scientific literature did not support airborne spread as the predominant mode of

transmission and that the latest World Health Organization (WHO) guidance hadn't changed in this respect.

Baroness Hallett questioned her closely on this point as she thought that WHO had changed their view on this. As can be seen in the video clip below, Dr Ritchie maintained her position, causing Baroness Hallett to apologise and admit she was at fault.

In fact it was Dr Ritchie at fault and Baroness Hallett who was correct. This definitive document, whose self-explanatory title '*Indoor airborne risk assessment*' sets out a description of the airborne transmission mechanism of SARS-CoV-2 (page 7): "*The high viral load percentile is comparable to the evidence observed in literature for outbreaks with (long-range) airborne transmission*

identified as the main mode of transmission".
It is a simple scientific fact that the concentration of aerosols giving rise to this long range risk will be very much greater within 1 metre of the patient where HCWs are delivering direct care. This is why they must have respiratory protection.

Given Dr Ritchie's position as Deputy Director of Infection Prevention and Control, a failure to understand the basic principles of transmission as currently defined by

WHO is extremely disturbing.

The Health and Safety Executive (HSE)

HSE is the regulatory organisation whose statutory role is to ensure that employers properly safeguard the health and safety of employees. They have the power to prosecute offenders and numerous other enforcement options.

They knew that Covid-19 was an airborne-transmissible disease. They

also knew that the fluid resistant surgical masks (FRSMs) which the IPC Cell insisted must be worn when providing close-quarter care of infectious patients, would be ineffective protection and put wearers at risk of the disease and death. Instead of asserting their moral and legal authority they abandoned HCWs to their fate, leaving them at the mercy of the IPC Cell and their flawed guidance.

Healthcare workers and patients

The third parties in this story are, of course, the doctors, nurses, midwives, paramedics, porters, healthcare assistants, cleaners—all healthcare workers, the list is endless. And, most importantly, the patients who went into hospital for various reasons other than Covid in the expectation of being made better, but who acquired Covid while in hospital and who died in their thousands.

IPC guidance:

The early days of the pandemic

Through January and February 2020, IPC guidance specified that HCWs must wear respirators such as FFP3s when dealing with suspected or confirmed Covid cases. This was in line with health and safety rules for airborne high consequence infectious diseases (HCIDs), such as this new virus, SARS-CoV-2.

However, on 31 Jan 2020 the IPC Cell approached the HSE to sound them out about

reducing the level of protection down to FRSM for GPs and others in primary care. It appears from email correspondence at the time that the IPC representative told HSE that they had undertaken a risk assessment that had concluded that the use of FRSM, rather than full RPE, would be appropriate.

Despite further FOI requests, no copy of that risk assessment has ever been forthcoming. This raises a question as to

whether it ever existed at all. According to health and safety law, risk assessments concerning employee safety must be recorded in writing and communicated to workers whom they might affect. HSE would surely have needed to see it before confirming that they approved it, saying that they considered it to be “proportionate and practical”.

Where an organisation claims to have done a 'risk assessment’ but it has never been formally

recorded, these are referred to as ghost assessments because, in the eyes of the law, they were never done. Organisations simply say they have done a risk assessment so as to purport that there is some credible basis for the things that they want to do. In reality, they are little more than a smoke screen to justify decisions made by a handful of people wishing to downgrade health and safety measures for political, economic or other reasons,

while lending them an air of credibility, authority and competency.

It is one of the worst forms of deception. It is also morally and ethically unconscionable when people's lives are at stake. In time of pandemic, when the country needs its HCWs to be at work, caring for their patients and not off sick, such a move is particularly reckless and negligent.

In early March, at the request of Professor Chris Whitty (Chief Medical Officer,

England), economies had to be made to conserve dwindling stocks of FFP3s. HCWs were only allowed FFP3s when caring for patients who were positively confirmed to have the disease. FRSMs would be worn when caring for those showing symptoms but not yet confirmed.

A week later, with stocks of FFP3s now running perilously low, the guidance changed yet again, this time denying virtually all HCWs the respiratory

protection they needed to keep them safe. Instead they were issued with FRSMs. **These brave people were quite rightly hailed as our frontline heroes in the war against the virus. However, equipping them with these flimsy masks, which are not even designated as PPE under UK safety legislation, was equivalent to sending frontline soldiers into battle with blanks in their rifles. They wouldn't know they couldn't protect themselves until it was too**

late.

The IPC Guidance in March 2020 read "*A FRSM must be worn when working in close contact (within 1 metre) of a patient with COVID-19 symptoms*". The word 'must' made this mandatory—an instruction which NHS Health Trusts and Health Boards were required to obey. Some commentators may interpret it as an instruction to expose their staff to mortal danger through inhalation of virus with the associated risk of disease and death—in direct

contravention of health, safety and human rights legislation. This instruction continued right through until June 2021.

PHE was officially designated as the lead Government department for the UK response to the pandemic emergency. Why was their advice not heeded? What authority did IPC Cell members have over PHE? Who assigned them that authority and why? Why would they not change their advice to recommend effective

respiratory protection in the face of the more transmissible and dangerous 'Kent'/'Alpha' variant?

Why was the HSE so impotent? Was it the decision of their Directors and Chief Executive to abandon health and safety law and enforce against the flawed IPC guidance instead?

IPC guidance from June 2021: Risk assessment for respiratory protection

Up until June 2021, the IPC guidance continued with the mandatory "*must wear FRSMs*" instruction and then a change happened. Perhaps by virtue of the fact that HSE, PHE, MPs and Ministers were coming under increasing pressure from professional bodies such as the BMA, Royal College of Nursing (RCN) and the AGP Alliance (now CATA) to recognise that IPC guidance was deeply flawed and out of step with health and safety legislation. So, for the first

time, 18 months into the pandemic, the concept of risk assessment was introduced in connection with decisions about whether or not RPE should be worn.

Although risk assessment had been mentioned in earlier versions of the guidance, that was more in terms of assessing the vulnerability of individuals (pregnancy, age, immunosuppressed, etc) or whether or not eye/face protection should be worn —all of which are fairly

straightforward forms of risk assessment.

This version introduced the text "O*rganisations should undertake local risk assessments based on the measures as prioritised in the hierarchy of controls. If an unacceptable risk of transmission remains following this risk assessment, it may be necessary to consider the extended use of RPE for patient care in specific situations*". At first sight this does not seem unreasonable since, in many

parts of a hospital building and for a considerable number of activities carried on there, the 'hierarchy of risk controls' can indeed be applied:

However, the one massive flaw in this thinking relates to the single most common task undertaken millions of times a day by HCWs across the UK. That is the provision of close-quarter, direct care of patients. This is where the

plume of exhaled breath from the infectious patient intermingles with the breathing zone of the HCW caring for them. At this point, none of the controls higher in the hierarchy apply —not even ventilation, since normal room ventilation does not create air movement at sufficient velocity to clear away the plume. We are left with the only option of PPE; in this case, specifically RPE to protect against inhaling the airborne virus.

In the video clip below [0min:32s] we see one of HSE's most distinguished microbiologists being interviewed on the subject of PPE for healthcare workers caring for patients during a pandemic. He explains that "*PPE is their last (and only) line of defence against exposure to the pathogen*". This is equally applicable to Covid-19 and any similar disease that presents a serious danger to health and may prove fatal or have serious long-term health effects.

Risk assessment for RPE: The 'Catch-22' situation

So the situation we had arrived at in June 2021 was that local NHS Trusts/ Boards had been given a task that was impossible; i.e., if we have a patient known to have the disease (or suspected through symptoms and local prevalence in the community) then it is not humanly possible to undertake a

suitable and sufficient risk assessment (the legal requirement for risk assessment) that can reliably inform a decision as to whether RPE should be worn as opposed to FRSM. You'll recall my earlier comment that risk assessment starts by identifying a hazard and, if you cannot do this, then you cannot do a risk assessment. Under this scenario:

- You cannot detect the

presence of infectious aerosols in the air by any of the human senses (sight, smell, etc).
- You cannot measure the concentration of the infectious agent (SARS-CoV-2) in the air by any

monitor, meter or any other instrument (as you can do with toxic gases, vapours, dusts and fibres).

- The effect of infection upon the worker cannot be reliably predicted.

Even young, healthy, non-pregnant health care workers can (and have) become seriously ill with Covid-19, with many going on to either die or develop serious chronic complications (Long

Covid)

.

So what is one to do in this 'Catch-22' situation? Well, as with any major health and safety issue, you look to the regulatory and advisory body to give official guidance, i.e., the HSE. However, none was ever forthcoming. HSE provides excellent guidance for most sectors of industry, but when it came to providing this crucial guidance for nurses, doctors, paramedics, etc, they failed to produce any. This was

strange because, for similar viruses like SARS-CoV-1 (2002-03), they stated that FFP3 respirators should be worn whereas they remained silent in respect of SARS-CoV-2.

So, at the HSE's general meeting (26 July 2022) a representative of the RCN asked a very specific question on this exact point. The question and answer by Mr Richard Brunt (HSE Director) can be seen in the video clip below [2m:27s].

Given the unsatisfactory, vague and evasive response in which he completely side-stepped the question, another RCN colleague pressed the point further, seeking some sort of clarity from HSE. The question and answer by Mr Brunt can be seen in the video clip below [1m:43s]. Mr Brunt concluded his brief and, once again, evasive answer by confirming his

view that it was down to "*local risk assessment*".

A further question was asked by the Chief Executive of the Society of Occupational Medicine who raised the point about the much higher death rates amongst health and social care workers and concern about the variation in risk assessment and the need for better oversight by HSE that had been

somewhat chaotic. The question and answer by Mr Philip White, HSE Director, can be seen in the video clip below [5m:30s].

One further point of interest from this same meeting was a most extraordinary remark by the HSE Chief Executive, Ms Sarah Albon. In this short clip she describes one of their key objectives in respect of safety communication

with workers. This can be seen in the video below [0m:22s].

.Although this comment was not made specifically in the context of healthcare, I suspect it will strike a chord with the thousands of HCWs who were on the receiving end of the "*really really good communication s*" to which Ms Albon referred, which had reassured them that surgical masks would keep them safe

against the virus…

Following on from Mr Brunt's comment about leaving RPE decisions to "*local risk assessment*" this letter was sent to him asking how the HSE, with all its experts in risk assessment, would itself carry out such a risk assessment of close-quarter care being given to an infectious patient. The key question raised in this letter is reproduced in Figure 1 below:

Figure1:
Question put to
Mr Brunt in
letter 11
August 2022

Predictably, no reply was received and, despite further chasing, two years later still no reply has been received from which the only conclusion that can be drawn is that, like me, they very well know that such a risk assessment is an impossible task. If that is not the case, then let them or their IPC colleagues prepare and publish a risk assessment methodology that is suitable and sufficient to determine

whether or not RPE should be worn by the HCW at close range of an infectious patient. IF they are able to do this, which I very much doubt, then perhaps they would explain why they didn't publish it back in June 2021 when it was most needed.

Fast forward two years and Mr Brunt is giving evidence to the UK Covid-19 Public Inquiry. As shown in the video below [9m:15s], Mr Stephen Simblet KC, Counsel for the Covid-19 Airborne Transmission

Alliance, is questioning Mr Brunt about that same meeting and asking some pertinent questions relating to the points raised by RCN/ SOM colleagues, to which Mr Brunt provides evasive answers.

During the questioning, Baroness Hallett (Inquiry Chair) interposes a searching question as to why HSE relied upon IPC Cell guidance when they knew that the disease was airborne

and they also knew that fluid-resistant surgical masks would not protect workers against an airborne disease? She also reminded him of HSE's statutory duty to protect the health and safety of three-quarters of a million frontline HCWs.

The final question put to Mr Brunt related to the central issue raised in this blog, and the letter sent two years ago (see above); i.e., that there is no realistic way for an individual HCW to carry out such a risk

assessment. Mr Brunt skilfully sidestepped the question, saying that "*he would agree entirely but it's not their responsibility to carry out a risk assessment, it's their employer's*". So if we don't expect the nurse, doctor, HCA, porter, etc, to do the risk assessment, it leaves the question of how 'the employer' is expected to carry out such a close-quarter risk assessment (i.e., their health and safety practitioner, IPC practitioner

or the occupational health practitioner). It is an impossible task is it not?

Mr Brunt, himself a registered Safety Practitioner and member of the Institution of Occupational Safety and Health, could have offered the Inquiry a more helpful answer than just to say "*it's the employer's responsibility*". His failure to properly engage with the question put to him suggests that, in reality, he agrees that such a risk

assessment is a complete impossibility.

And so we are left with the question hanging in the air: Is this simply a question of this being 'a risk assessment too far'?

"In good faith"

As time goes on, we may well hear more comments such as "*difficult decisions*" "*made at pace*" and "*made in good faith*". We have already heard Sir Jeremy Farrar (Chief Scientific Advisor, World Health

Organization) use the term in the context of WHO 'experts' dogmatically pronouncing that Covid-19 was definitely not airborne despite the clamour of experts telling them that it was. Despite the good faith remark, he acknowledged that if these people had made better decisions about aerosol transmission "*that would have saved an enormous number of lives*".

The term good faith is a very clever one to use since, looking back over history, it

could be made about any action, no matter how heinous it was or how horrendous the consequences. The intention is to make anyone who is minded to criticise the perpetrator feel guilty about voicing their concerns because "*after all, they acted in good faith*"!

We are likely to hear the term used again in connection with similar decisions made by the IPC Cell 'experts' who persistently denied the airborne route of transmission and ignored

anyone who dared to say otherwise. There is no reason why Sir Jeremy's comments cannot equally be applied to the UK situation; i.e., had the IPC Cell accepted airborne transmission earlier, it would have saved an enormous number of lives.

In the context of Covid-19 we should not allow ourselves to be duped by anyone playing the good faith (get-out-of-jail-free) card.

Ghost risk assessments

I referred earlier to health authorities purporting to have carried out risk assessment in order to justify the downgrading of safety precautions, especially where the proposed change may be controversial.

An example of this can be seen at the time when Government policy was “pandemic over – everyone get back to normal” and precautions such as 'universal masking' in hospitals and other healthcare

premises was abandoned, despite the fact that healthcare-acquired infections of Covid-19 was still running at around 30%. Norfolk and Norwich University Hospitals NHS Foundation Trust was around the first to implement the change. As their press release confirmed, they announced that the decision had been taken following—you guessed it —"*local risk assessment*". By way of a test, I submitted a FOI request to have sight of their local risk assessments.

This was met with silence, which led to the suspicion that the press statement was untrue. After 16 months of chasing for an answer (which should, by law, be provided within 20 working days) and only after the Information Commissioners Office forced their hand, was a response received. The Trust was unable to produce any documented risk assessments. This rather illustrates the point about ghost risk assessments.

Reflection

I hope that you have found this blog thought-provoking as we remember those awful days at the height of the pandemic – the consequences of which still blight so many peoples' lives today. **Sadly, of course Covid is not over, despite the Government and the media continuously referring to it in the past tense. We know that repeat infections increase the risk of Long Covid even if the acute stage of the disease doesn't hit too hard.** The long term effects (especially on children in the

years and decades to come) are not well known. However, all the information I have seen suggests that our current lackadaisical approach to the disease could be a ticking time-bomb, with future generations looking back on us with incredulity, asking "*why did they not do more to protect us*?"

In this blog, I have focussed mostly on just two organisations (IPC Cell, HSE) but there are so many other people involved that warrant scrutiny.

However, I would like to finish by addressing a particularly important issue.

I listened attentively as Ms Carey KC, Counsel to the UK Covid Public Inquiry, concluded her excellent opening statement on 9 September 2024. She condemned the abuse, insults and threats to which some public servants and even their families have been subjected. That is horrendous and I absolutely share that condemnation. As Ms Carey went on to say,

this doesn't mean that their decisions should not be scrutinised so that opinions can be formed.

Where appropriate, there are a number of sanctions that can be applied, which are more in keeping with civilised society than insults and threats. We have recently seen, in the case of Rev Paula Vennells (formerly CBE), in the Post Office scandal how individuals whose acts or omissions were so gross that it called into question their fitness to continue

holding medals or other honours that the nation has bestowed upon them. Fitness to continue serving in their current jobs may also be called into question if their past performance is shown to have been inept.

Finally, there is the ultimate sanction of prosecution if any acts or omissions were in breach of the law. However, in reaching any such decisions, the Crown Prosecution (or other enforcement agency) is required to apply 'the public interest

test'. To my mind, one of the factors that would need to be considered is the consequences for the next pandemic. Would it be in the country's best interests for all our scientific and medical leaders to quit their jobs as soon as a new pandemic emerges on the grounds that their predecessors were hauled before the Courts? On that possibly controversial note I will end this blog.

Further reading on *the hub*:

- Respir

atory protective equipment: An unequal solution for health care workers? A blog by David Osborn

- The pandemic – questions around Government governance: a blog from David Osborn

Raising concerns about PPE and ventilation as a Junior Doctor, a blog by Lindsay Fraser-Moodie

- PPE guidance continues to put staff and patients at risk, by Dr David Tomli

nson

About the Author

David Osborn is a chartered occupational safety and health practitioner, having been in practice for 30 years. He has a background in biochemistry, microbiology, epidemiology and emergency planning. Any blogs or letters that David writes to Government departments, Agencies or the NHS are written entirely on a personal and individual basis and do not necessarily reflect the

views of any organisations to which he is affiliated.

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